ONE HUNDRED TENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

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September 19, 2008

Mr. Herb Kuhn
Acting Director
Center for Medicaid & State Operations
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Mr. Kuhn:

Since the death of twelve-year old Deamonte Driver of Prince George's County, Maryland, who died of a brain infection caused by untreated tooth decay, the Domestic Policy Subcommittee has been investigating the adequacy of pediatric dental services under Medicaid. Our findings reveal that the dismal character of the Medicaid dental program in Maryland as it existed in early 2007 is not unique.[1] Instead, our findings demonstrate that inadequate access to and unsatisfactory utilization rates of pediatric dental care under Medicaid is prevalent in three other states and counties we surveyed, and among three other managed care organizations.

In the aftermath of its first hearing in May 2007, the Subcommittee launched a review of UnitedHealth Care's ("United")[2] documents and found that nearly 11,000 Maryland children enrolled in United had not seen a dentist in four or more consecutive years putting them in the same precarious position Deamonte was in at the time of his tragic death. The review also revealed that United's dental provider network was not nearly as robust as United had claimed:

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[1] In February 2007, twelve-year old Deamonte Driver, died of a brain infection caused by untreated tooth decay. A Subcommittee investigation into the matter revealed chronic underutilization among a significant number of children enrolled in UnitedHealth Care throughout Maryland as well as a inadequate dental provider network. Since the death of Deamonte as well the Subcommittee investigation, Maryland has taken significant steps to reform its pediatric dental care under Medicaid.

[2] UnitedHealthCare was the managed care organization responsible for Deamonte at the time of his death.

Only seven dentists conducted 55% of all dental services rendered in 2006 in the county where Deamonte resided.[3]

Shortly after the release of our investigatory findings in October 2007, the Subcommittee expanded its investigation to four other states and counties and three additional managed care organizations ("MCO's") in addition to United. The Subcommittee sought to evaluate whether United's woefully inadequate provider network in Prince George's County and its extremely low utilization rate throughout Maryland were unique. The Subcommittee expanded its review of United in Apache County, Arizona; Essex County, New Jersey; Philadelphia County, Pennsylvania; and Providence County, Rhode Island.[4] In addition to evaluating United's performance in these jurisdictions, the Subcommittee also evaluated the performance of three other MCO's with presence in those counties and states, these included: HealthChoice in Arizona, Keystone Mercy in Pennsylvania, and Amerigroup in New Jersey and Maryland.[5]

The Subcommittee reviewed the dental claims in FY 2006 for each of these MCOs to evaluate:

(1) Whether services rendered in each county were provided by a broad spectrum of dentists, or whether they were provided by only a handful of dentists as was the case with United in Prince George's County;

(2) Whether there existed a significant number of children in each state who did not receive dental care for four consecutive years, between 2003 and 2006, as was the case with children enrolled in United in Maryland; and

(3) Whether the dental provider network provided by each of the MCOs was accurate and reliable, or whether it was replete with erroneous listings including dentists that did not take any new Medicaid patients as was the case with United in Prince George's County.

Our findings are as follows:

(1) The percentage of children enrolled in Medicaid without dental services for four consecutive years between 2003 and 2006 ranged between 25 and 31 percent across all states and MCO's;

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[3] Letter to United and Department of Health and Mental Hygiene from Domestic Policy Subcommittee, Committee on Oversight and Government Reform (October 2, 2007)(online http://domesticpolicy.oversight.house.gov/documents/20071003151743.pdf).

[4] United's presence in Rhode Island only amounted to one quarter of FY 2006 and therefore did not provide useful claims data to be included in the review.

[5] Document Request submitted to United from Subcommittee (January 8, 2008); Document Request submitted to HealthChoice from Subcommittee (April 28, 2008); Document Request submitted to Amerigroup from Subcommittee (April 28, 2008); Document request submitted to Keystone Mercy from Subcommittee (April 28, 2008).

(2) In all jurisdictions and among all MCOs examined, between two and nine dentists performed 50 percent of all services rendered to children enrolled in Medicaid in FY 2006; and

(3) The dental provider networks surveyed are marginally better than United's network in Prince George's County but still far from adequate. Our survey revealed problems in the accuracy of the provider listings as well as severe problems in access to dentists for children enrolled in Medicaid. Significantly, many of the dentists accurately listed are not willing to serve children enrolled in Medicaid. For example, in Prince George's County, Maryland, United's dental provider network was 70 percent accurate, meaning that 51 of its 73 listed dentists existed, had the correct contact information listed, and accepted Medicaid patients. However, the claims data demonstrates that of the 51 dentists accurately listed, 19 dentists provided zero services to eligible children in Prince George's County and that 22 of them provided services to only one child merely a single time. In effect, of the 51 accurate listings only ten of them are likely to see a child enrolled in Medicaid. Our review demonstrates that accuracy of the listings ranged from 42% (Philadelphia County, Keystone Mercy) to 80% (Apache County, UnitedHealth Care).

The following charts show our findings for each MCO in each state and county. Also, you will find a memo from the Congressional Research Service to the Subcommittee summarizing their analysis of the claims data done on behalf of the Subcommittee.

Chronic Underutilization: Lack of Dental Care in Four Consecutive Years: 2003 - 2006

Managed Care Organization		Pennsylvania - Philadelphia	Arizona - Apache	New Jersey - Essex	Maryland - Prince George's
Americhoice	Percent of Enrollees with No Service	28%	0.1%	28%	Note 2
	Number of Enrollees with No Service	10,225	69	22,231	10,780
AmeriGroup	Percent of Enrollees with No Service	*N/A*	*N/A*	25%	24%
	Number of Enrollees with No Service	*N/A*	*N/A*	5,715	14,076
HealthChoice	Percent of Enrollees with No Service	*N/A*	28%	*N/A*	*N/A*
	Number of Enrollees with No Service	*N/A*	8,948	*N/A*	*N/A*
Keystone Mercy	Percent of Enrollees with No Service	31%	*N/A*	*N/A*	*N/A*
	Number of Enrollees with No Service	34,947	*N/A*	*N/A*	*N/A*

Note: Enrollment numbers reflect enrollees who were enrolled over the four year period 2003- 2006 and received no services. **Note 2**: The Subcommittee's review of United's dental provider network in Prince George's County, Maryland took place in the Fall of 2007. At that time the Majority Staff did not request the total number of children enrolled in United between 2001 and 2006—having that number would have enabled the Subcommittee to determine the percentage of children with no services for four consecutive years. Instead the Subcommittee's figures only reflect the total number of children enrolled in United in each year between 2001 and 2006.
N/A - managed care organization does not enroll beneficiaries in county.

Concentration of Dental Services Rendered: Number of Dentists in each county who provided 50% of dental services rendered for all Medicaid enrolled children in 2006

Managed Care Organization		Pennsylvania - Philadelphia	Arizona - Apache	New Jersey - Essex	Maryland - Prince George's
Americhoice	Number of providers that represent ~50% of care	**8**	**2**	**9**	**7**
	Total number of providers, percentage, and claims	(177 providers) 51.3% services 18,753/38,160 claims	(76 providers) 50% of services 1104/2254 claims	(203 providers) 51.9% of services 7816/16404 claims	(73 providers) 50% of services
AmeriGroup	Number of providers that represent ~50% of care			**9**	**8**
	Total number of providers, percentage, and claims			(59 providers) 49.7% of services 2,638/5293 claims	(71 providers) 51.9% of services 12,433/23,966 claims
HealthChoice	Number of providers that represent ~50% of care		**2**		
	Total number of providers, percentage, and claims		(21 providers) 53% of services 166/312 claims		
Keystone Mercy	Number of providers that represent ~50% of care	**4**			
	Total number of providers, percentage, and claims	(160 providers) 53.7% 49, 635/92,493 claims			

These troubling figures demonstrate that the oral health crisis that manifested in Maryland in early 2007 is imminent in at least four other states, regardless of which MCO is responsible for administering pediatric dental care under Medicaid. The Subcommittee fears that this could be true throughout the country as well.

The Subcommittee requests that CMS address these findings and identify how it proposes to substantially improve pediatric dental care under Medicaid. Please be prepared to do so during the Subcommittee's hearing on Tuesday September 23rd. Please submit something in writing as well.

The Oversight and Government Reform Committee is the principal oversight committee in the House of Representatives and has broad oversight jurisdiction as set forth in House Rule X. An attachment to this letter provides information on how to respond to the Subcommittee's request.

If you have any questions regarding this request, Noura Erakat, Counsel, at (202) 226-5867.

Sincerely,

Dennis J. Kucinich
Chairman
Domestic Policy Subcommittee

Enclosure

cc: Darrell Issa
Ranking Minority Member

Domestic Policy Subcommittee Document Request Instruction Sheet

In responding to the document request from the Domestic Policy Subcommittee, Committee on Oversight and Government Reform, please apply the instructions and definitions set forth below.

Instructions

1. In complying with the request, you should produce all responsive documents in your possession, custody, or control.

2. Documents responsive to the request should not be destroyed, modified, removed, transferred, or otherwise made inaccessible to the Subcommittee.

3. In the event that any entity, organization, or individual denoted in the request has been, or is currently, known by any other name than that herein denoted, the request should be read also to include them under that alternative identification.

4. Each document produced should be produced in a form that renders the document capable of being copied.

5. When you produce documents, you should identify the paragraph or clause in the Subcommittee's request to which the documents respond.

6. Documents produced in response to this request should be produced together with copies of file labels, dividers, or identifying markers with which they were associated when this request was issued. To the extent that documents were not stored with file labels, dividers, or identifying markers, they should be organized into separate folders by subject matter prior to production.

7. Each folder and box should be numbered, and a description of the contents of each folder and box, including the paragraph or clause of the request to which the documents are responsive, should be provided in an accompanying index.

8. It is not a proper basis to refuse to produce a document that any other person or entity also possesses a nonidentical or identical copy of the same document.

9. If any of the requested information is available in machine-readable or electronic form (such as on a computer server, hard drive, CD, DVD, memory stick, or computer backup tape), you should consult with Subcommittee staff to determine the appropriate format in which to produce the information.

10. The Committee accepts electronic documents in lieu of paper productions. Documents produced in electronic format should be organized, identified, and indexed electronically in a manner comparable to the organizational structure called for in (6) and (7) above. Electronic document productions should be prepared according to the following standards:

    (a) The production should consist of single page TIF files accompanied by a Concordance-format load file, an Opticon reference file, and a file defining the fields and character lengths of the load file.

    (b) Document numbers in the load file should match document Bates numbers and TIF file names.

    (c) If the production is completed through a series of multiple partial productions, field names and file order in all load files should match.

11. In the event that a responsive document is withheld on any basis, you should provide the following information concerning the document: (a) the reason the document is not being produced; (b) the type of document; (c) the general subject matter; (d) the date, author, and addressee; and (e) the relationship of the author and addressee to each other.

12. If any document responsive to this request was, but no longer is, in your possession, custody, or control, you should identify the document (stating its date, author, subject and recipients) and explain the circumstances by which the document ceased to be in your possession, custody, or control.

13. If a date or other descriptive detail set forth in this request referring to a document is inaccurate, but the actual date or other descriptive detail is known to you or is otherwise apparent from the context of the request, you should produce all documents which would be responsive as if the date or other descriptive detail were correct.

14. This request is continuing in nature and applies to any newly discovered document. Any document not produced because it has not been located or discovered by the return date should be produced immediately upon location or discovery subsequent thereto.

15. All documents should be bates-stamped sequentially and produced sequentially. In the cover letter, you should include a total page count for the entire production, including both hard copy and electronic documents.

16. For paper productions, four sets of documents should be delivered: two sets to the majority staff and two sets to the minority staff. For electronic productions, one dataset to the majority staff and one dataset to minority staff are sufficient. Productions should be delivered to the majority staff in B-349B Rayburn House Office Building and the minority staff in B-350A Rayburn House Office Building. You should consult with Subcommittee staff regarding the method of delivery prior to sending any materials.

17. Upon completion of the document production, you should submit a written certification, signed by you or your counsel, stating that: (1) a diligent search has been completed of all documents in your possession, custody, or control which reasonably could contain responsive documents; and (2) all documents located during the search that are responsive have been produced to the Subcommittee or identified in a privilege log provided to the Subcommittee.

Definitions

1. The term "document" means any written, recorded, or graphic matter of any nature whatsoever, regardless of how recorded, and whether original or copy, including, but not limited to, the following: memoranda, reports, expense reports, books, manuals, instructions, financial reports, working papers, records notes, letters, notices, confirmations, telegrams, receipts, appraisals, pamphlets, magazines, newspapers, prospectuses, interoffice and intra-office communications, electronic mail (email), contracts, cables, notations of any type of conversation, telephone calls, meetings or other communications, bulletins, printed matter, computer printouts, teletypes, invoices, transcripts, diaries, analyses, returns, summaries, minutes, bills, accounts, estimates, projections, comparisons, messages, correspondence, press releases, circulars, financial statements, reviews, opinions, offers, studies and investigations, questionnaires and surveys, and work sheets (and all drafts, preliminary versions, alterations, modifications, revisions, changes, and amendments of any of the foregoing, as well as any attachments or appendices thereto). The term also means any graphic or oral records or representations of any kind (including without limitation, photographs, charts, graphs, voice mails, microfiche, microfilm, videotape, recordings and motion pictures), electronic and mechanical records or representations of any kind (including, without limitation, tapes, cassettes, disks, computer server files, computer hard drive files, CDs, DVDs, memory sticks, and recordings), and other written, printed, typed, or other graphic or recorded matter of any kind or nature, however produced or reproduced, and whether preserved in writing, film, tape, disk, videotape or otherwise. A document bearing any notation not a part of the original text is to be considered a separate document. A draft or non-identical copy is a separate document within the meaning of this term.

2. The term "documents in your possession, custody, or control" means (a) documents that are in your possession, custody, or control, whether held by you or your past or present agents, employees, or representatives acting on your behalf; (b) documents that you have a legal right to obtain, that you have a right to copy, or to which you have access; and (c) documents that you have placed in the temporary possession, custody, or control of any third party.

3. The term "communication" means each manner or means of disclosure or exchange of information, regardless of means utilized, whether oral, electronic, by document or otherwise, and whether face-to-face, in a meeting, by telephone, mail, telexes, discussions, releases, personal delivery, or otherwise.

4. The terms "and" and "or" shall be construed broadly and either conjunctively or disjunctively to bring within the scope of the request any information which might otherwise be construed to be outside its scope. The singular includes plural number, and vice versa. The masculine includes the feminine and neuter genders.

5. The terms "person" or "persons" means natural persons, firms, partnerships, associations, corporations, subsidiaries, divisions, departments, joint ventures,

proprietorships, syndicates, or other legal, business or government entities, and all subsidiaries, affiliates, divisions, departments, branches, and other units thereof.

6. The terms "referring" or "relating," with respect to any given subject, means anything that constitutes, contains, embodies, reflects, identifies, states, refers to, deals with, or is in any manner whatsoever pertinent to that subject.

Congressional Research Service

Memorandum September 18, 2008

TO: House Committee on Oversight and Government Reform
Subcommittee on Domestic Policy
Attention: Noura Erakat

FROM: Elicia Herz and Rich Rimkunas
Specialists in Social Legislation
Domestic Social Policy Division

SUBJECT: Analysis of Medicaid Dental Claims for Children in Three States

To assist you in preparation for your Subcommittee hearing on September 23, 2008, at your request, we have analyzed dental claims data from selected Medicaid managed care plans in three states (Arizona, New Jersey, and Pennsylvania).[1] To supplement this claims analysis, we also provide analyses of FY2006 CMS-416 data, which documents receipt of dental services among Medicaid children eligible to receive early and periodic screening, diagnostic and treatment (EPSDT) services, a mandatory benefit for individuals under 21 in Medicaid.

Background

Lack of regular dental care can result in pain, infection and delayed diagnosis of oral diseases. During the 2001 - 2004 period, one-fourth to one-third of children ages 2 to 19 in families with income below 200% of the federal poverty level (FPL) experienced untreated dental caries, a sign that needed dental care was not received. In 2005, about one-third of all children living below 200% FPL did not have a recent dental visit.[2]

In 2006, 50.9% of individuals under the age of 21 in the U.S. had private dental coverage, another 30.4% had public dental coverage (primarily Medicaid and SCHIP) and 18.7% had no dental coverage. The percentage of individuals under age 21 that had a dental visit in 2006 varies by type of coverage – 58.0% with private dental coverage had a dental

[1] The committee also asked CRS to analyze activities in Rhode Island. The Rhode Island data reflected a single quarter (3 months) of data. This was not a long enough period of time to determine beneficiary access patterns or provider service activity. As a result, the Rhode Island information is not included in this memorandum.

[2] National Center for Health Statistics, *Health, United States, 2007 With Chartbook on Trends in the Health of Americans*, Hyattsville, MD: 2007. Hereafter referenced as *Health, United States, 2007.*

visit that year, compared to 35.1% of those with public dental coverage and 26.3% of the subgroup with no dental coverage.[3]

With respect to the first dental visit, the American Academy of Pediatric Dentistry (AAPD) recommends that every child be seen by a dentist following the eruption of the first tooth, but not later than 12 months of age. All other children should have additional periodic dental exams every 6 months (i.e., twice a year). Under Medicaid, states must adopt a dental periodicity schedule which can be state-specific based on consultation with dental groups, or may be based on nationally recognized dental periodicity schedules, such as the AAPD's guidelines.[4]

One goal of the *Healthy People 2010* initiative is that at least 57% of low-income children receive a preventive dental visit each year.[5] Most Medicaid children under age 21 are entitled to EPSDT services.[6] The Medicaid statute (Section 1905(r)) defines required EPSDT screening services to include dental services which, at a minimum, include relief of pain and infections, restoration of teeth, and maintenance of dental health. In addition, care that is necessary to correct or ameliorate identified problems must also be provided, including optional services that states do not otherwise cover in their Medicaid programs. Beneficiary cost-sharing for services such as dental care is prohibited for children under age 18, and is optional for those between ages 18 - 21.[7]

The research literature has identified several factors that affect the use of dental services among children. From a beneficiary perspective, barriers include, for example, ability to pay for care, navigating government assistance programs, finding a dentist who will accept Medicaid, locating a dentist close to home (especially in inner-city and rural areas), getting to a dentist office, cultural or language barriers, and lack of knowledge about the need for periodic oral health care.[8]

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[3] See Manski, R.J. and Brown, E. *Dental Coverage of Children and Young Adults Under Age 21, United States, 1996 and 2006.* Statistical Brief (forthcoming). Agency for Health Care Research and Quality, Rockville, MD.

[4] See Centers for Medicare and Medicaid Services (CMS), *Guide to Children's Dental Care in Medicaid*, October 2004, and the American Academy of Pediatric Dentistry, *Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment of Children*, 2003.

[5] U.S. Department of Health and Human Services. *Healthy People 2010.* Second Edition. Washington, DC: U.S. Government Printing Office, November 2000.

[6] Children classified as "medically needy" (in most states, a small subset of all Medicaid children), may be provided EPSDT at state option. Although an official count is not available, we believe that all states currently provide EPSDT to this group. In addition, as an alternative to traditional Medicaid benefits, the Deficit Reduction Act (DRA) of 2005 allows states to offer benchmark plans similar to coverage in the employer-based insurance market to many groups of Medicaid beneficiaries. This DRA option provides access to EPSDT as a "wrap-around" to these benchmark plans for Medicaid beneficiaries under age 19, not under age 21, as in traditional Medicaid.

[7] Under the DRA, cost-sharing is prohibited only for children in mandatory eligibility categories (e.g., the poorest children) and certain foster care/adoption assistance children. Exempted groups may nonetheless be subject to cost-sharing for non-emergency use of an emergency room and prescribed drugs at state option.

[8] *Health, United States, 2007.*

Because most of the dental care provided in the U.S. is delivered by private dentists, their participation in Medicaid is critical to access to these services. Dentists typically cite three main reasons for their low participation rates in Medicaid: (1) low reimbursement rates, (2) burdensome administrative requirements, (3) and patient behavior (e.g., infrequent care-seeking behavior and high no-show rates for dental appointments).[9] Medicaid law and regulations require that payment rates be sufficient to enlist enough providers so that services are available at least to the same extent that such services are available to the general population in the geographic area.

Managed Care Plans in Three Study States

In the past, benefits through managed care plans focused mostly on primary and acute medical care services. Delivery of both institutional and non-institutional long-term care (e.g., nursing home care, home health services) was typically provided by Medicaid programs in the fee-for-service setting rather than through managed care arrangements. Such was also the case for dental services. In early 2000, the GAO conducted a study examining factors contributing to the low use of dental services by low-income populations.[10] In that study, GAO determined that 20 states used managed care to provide some dental services to Medicaid beneficiaries. More recent data from CMS show that, as of June 30, 2006, 32 states had managed care arrangements that included coverage of dental services.[11]

The Domestic Policy Subcommittee of the House Oversight and Government Reform Committee requested that CRS analyze dental claims data from selected managed care plans in three study states – Arizona, New Jersey, and Pennsylvania. Statewide and county-specific claims data for the AmeriChoice Managed Care Organization (MCO) were available for Arizona (statewide and Apache County), New Jersey (statewide and Essex County), and Pennsylvania (statewide and Philadelphia County). Additional claims data were available for the AmeriGroup MCO in Essex County, New Jersey, the Keystone MCO in Philadelphia County, Pennsylvania, and the HealthChoice MCO in Apache County, Arizona. These data allowed for the comparison of two different MCOs operating in the same county in three distinct parts of the nation.

The Subcommittee asked CRS to look at two aspects of Medicaid dental services:

- What share of MCO enrollees did not receive dental services, despite multiple years of MCO enrollment?
- How many providers in each county actually delivered services to enrollees (as measured by the number of Medicaid paid claims processed by the MCO in fiscal year 2006)? In particular, is there a concentration of providers that actively deliver services in these particular counties?

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[9] See, for example, S. Gehshan and M. Wyatt, *Improving Oral Health Care for Young Children*, National Academy for State Health Policy, April 2007, and A. Borchgrevink, A. Snyder, and S. Gehshan, *The Effects of Medicaid Reimbursement Rates on Access to Dental Care*, National Academy for State Health Policy, March, 2008.

[10] The General Accounting Office (GAO), *Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations*, GAO/HEHS-00-149, September, 2000.

[11] See Centers for Medicare and Medicaid Services, *2006 National Summary of State Medicaid Managed Care Programs: Program Descriptions as of June 30, 2006* (pages 653 - 654) at http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/nationalsummreport06.pdf.

Claims Data – Findings on Receipt of Dental Services Among Children in Selected Managed Care Plans in the Three Study Areas

Table 1 provides an analysis of the number of enrollees in each of the study areas who: (a) were continuously enrolled in the MCO beyond a single year, and (b) the number who did not receive any dental services. In general, the longer a child was enrolled in a MCO, the higher the likelihood that the child had some dental services paid for by the MCO in all three of the study states, regardless of the specific MCO. Also, despite continuous enrollment over multiple years, a large share of children enrolled in any of the study MCOs did not have a dental service claim paid by the MCO during the study period. For example, during three years of continuous enrollment, between 30 and 40 percent of enrollees had no paid dental claims in the three study sites. The accompanying **chart** provides a comparison of each of the study sites and MCOs, taking into account different time periods of continuous coverage.

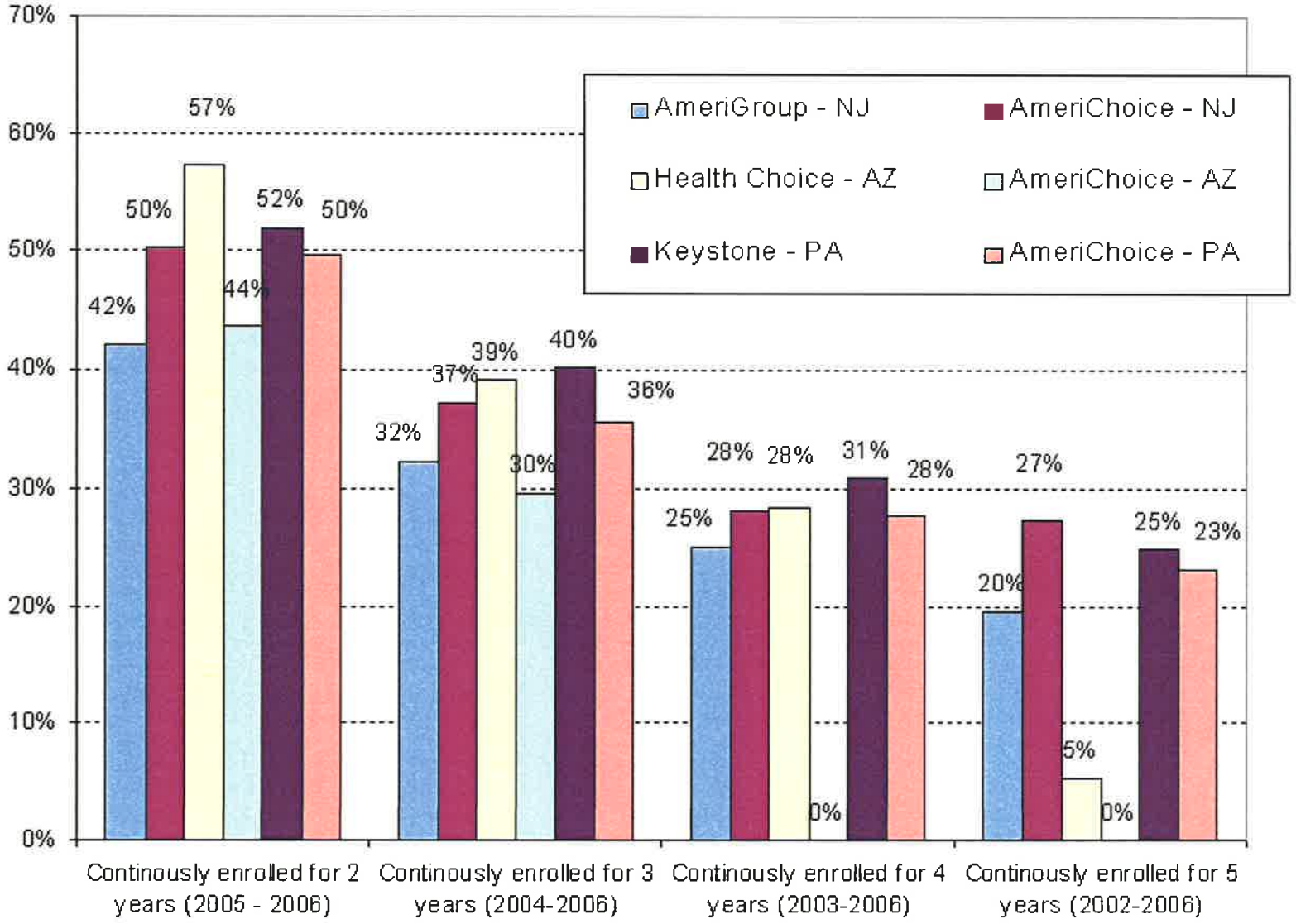
It should be noted that these estimates are based on enrollees with paid dental service claims. In some instances, individual members may have received dental services outside of the MCO or received dental services without generating a paid claim. Such services were not captured in these estimates.

Table 1. Comparison of the Number of Enrollees with No Paid Claims in Selected Medicaid Managed Care Organizations, 2002 - 2006

Years of Enrollment	Total Enrollees	Number of Enrollees with No Paid Dental Claims	Percent of Enrollees with No Paid Dental Claims
Apache Arizona – HealthChoice			
2005 - 2006	69,433	39,841	57%
2004-2006	46,091	18,053	39%
2003-2006	31,483	8,948	28%
2002-2006	17,786	950	5%
Apache Arizona - AmeriGroup			
2005 - 2006	186,287	81,314	44%
2004-2006	141,565	41,949	30%
2003-2006	111,442	69	0%
2002-2006	80,093	0	0%
AmeriGroup – Essex New Jersey			
2005 - 2006	54,975	23,146	42%
2004-2006	35,392	11,436	32%
2003-2006	22,905	5,715	25%

Years of Enrollment	Total Enrollees	Number of Enrollees with No Paid Dental Claims	Percent of Enrollees with No Paid Dental Claims
2002-2006	14,164	2,781	20%
AmeriChoice – Essex New Jersey			
2005 - 2006	134,766	67,978	50%
2004-2006	102,178	37,982	37%
2003-2006	79,344	22,231	28%
2002-2006	56,319	15,394	27%
Keystone Mercy – Philadelphia Pennsylvania			
2005 - 2006	183,903	95,509	52%
2004-2006	144,970	58,314	40%
2003-2006	113,008	34,947	31%
2002-2006	91,208	22,651	25%
AmeriChoice – Philadelphia Pennsylvania			
2005 - 2006	56,307	27,989	50%
2004-2006	44,879	16,005	36%
2003-2006	36,993	10,225	28%
2002-2006	30,115	6,976	23%

Share of Enrollees with No Dental Service over Selected Time Periods



Claims Data – Findings on Provider Concentration in Selected Managed Care Plans in Three States

Table 2 provides summary information on the number of providers with paid claims, the number of providers with 10 or more claims, the number of providers with more than 50% of the paid claims, and the total number of paid claims.

Table 2. Selected Provider Characteristics Among Four Medicaid Managed Care Organizations, 2006

Managed Care Organization	Number of providers with paid claims	Number of providers with 10 or more claims	Number of providers that represent more than 50 percent of claims	Total number of paid claims
HealthChoice - Apache Arizona	21	4	2	312
AmeriChoice -- Appache Arizona	76	15	3	2,254
AmeriGroup - Essex New Jersey	59	50	10	5,293
AmeriChoice - Essex New Jersey	203	88	9	16,404
Keystone Mercy -- Philadelphia Pa.	160	130	4	92,493
AmeriChoice -- Philadelphia Pa.	177	136	8	38,160

The number of providers with at least one paid claim in the three study localities varies from a low of 21 providers with paid claims in Apache County, Arizona to 203 providers in Essex County, New Jersey. Variation in the number of providers with paid claims is not surprising; the population of eligible children varies dramatically from one locale to another. For instance, in 2006, the average monthly enrollment in Apache County, Arizona, for the HealthChoice MCO equaled 820 children (the average monthly enrollment for AmeriChoice in the same county equaled 1,932); the average monthly enrollment in Essex County, New Jersey, for AmeriChoice equaled 20,597 (the comparable figure for AmeriGroup in the same county equaled 9,125). There is no simple measure of the adequacy of a provider network. However, these data suggest that there is substantial variation in the number of providers with paid claims relative to the number of enrollees in each of the MCOs.

Another measure to consider in determining the adequacy of a dental provider network is to determine the distribution of paid claims among participating providers. There are numerous reasons why this is a crude measure of network adequacy. For example, this measure does not consider how easy it is to schedule an appointment and then to actually get to the provider and receive dental services. In addition, some Medicaid beneficiaries may have special needs and may be best seen by providers with special training, equipment and experience treating such patients. For example, in Philadelphia, *Special Smiles Limited* is dedicated to providing dental services for children and adults with special needs. The dentists at this facility provide a large amount of care in both Medicaid managed care organizations in the Philadelphia study area.

These limitations being recognized, there is a consistent pattern across all the study MCOs in this analysis. In all instances, a relative small number of providers account for a large share of the

paid dental claims. For example, in the Keystone Mercy MCO in Philadelphia, 4 of 160 providers accounted for more than 50% of paid claims. Likewise, in the AmeriGroup MCO in Essex County, New Jersey, 10 of 59 providers accounted for more than 50% of paid claims.

CMS-416 Data – State-Level Findings on Receipt of Dental Services Among EPSDT Participants

The Medicaid statute (Section 1902(a)(43)) requires states to inform and arrange for the delivery of EPSDT services to eligible children, and also includes annual reporting requirements for states. Among several requirements, states must report the number of children receiving dental services. The tool used to capture these required EPSDT data is called the CMS-416 form. The current CMS-416 form (effective as of FY1999) includes the unduplicated count of EPSDT eligibles by age and basis of eligibility who receive (1) any dental services, (2) preventive dental services, and (3) dental treatment services. Classification into one of these measures is based on specific dental procedure codes recorded on provider claims.

Tables 3 - 5 show receipt of dental services among EPSDT eligibles in the three study states, and other reporting states combined, for FY2006.

Receipt of Any Dental Services. For all children under age 21, the three study states combined had a somewhat lower proportion receiving any dental services (29%) compared to all other reporting states combined (33%), as shown in **Table 3**. Across age groups, children ages 6 to 9 years had the highest rates of receiving any dental services, ranging from 36% to 54% among the three study states, compared to 47% for all other reporting states combined. The higher rates of dental care receipt among this age group may be related to school entry, since young children are typically required to be up-to-date on certain immunizations to attend school. As a part of those immunization visits, physicians may also make references for dental care for these children.

Table 3. Percentage of EPSDT Eligibles Receiving Any Dental Services by Age Group, FY2006

States	Total	Under 1	1 - 2	3 to 5	6 to 9	10 to 14	15 to 18	19 to 20
AZ	33.6	0.1	7.7	41.4	54.1	47.2	32.1	17.8
NJ	25.9	0.5	5.3	27.8	35.9	34.8	30.9	21.3
PA	27.2	0.1	4.9	30.7	38.3	35.1	30.4	19.9
Study States Combined	28.6	0.2	5.9	33.1	42.1	38.0	30.9	19.8
Other Reporting States	33.1	0.8	13.3	39.5	46.8	42.7	34.2	20.5
Total Reporting States	32.8	0.7	12.7	39.0	46.4	42.4	34.0	20.4

Source: FY2006 CMS-416 reports, provided to CRS as of August, 28, 2008. Data for Kentucky, Maine and Vermont were not available, and thus, these states are excluded from these analyses.

Receipt of Preventive Dental Services. One of the three study states – Arizona (28%) – had rates for preventive dental care among all children under 21 that were the same as or better than the 28% average for all other reporting states combined (see **Table 4**). Again, the percentage of children receiving preventive dental services was highest among the 6 to 9 year old age group compared to other age groups.

While none of the three study states reached the 57% participation goal for preventive dental care among children established in *Health People 2010,* Arizona was closest for the subgroup between the ages of 6 and 9. Among the other reporting states, two exceeded this goal for children ages 6 to 9 years – Nebraska and South Carolina (57.9% and 65.1%, respectively; data not shown).

Table 4. Percentage of EPSDT Eligibles Receiving Preventive Dental Services by Age Group, FY2006

States	Total	Under 1	1 to 2	3 to 5	6 to 9	10 to 14	15 to 18	19 to 20
AZ	28.0	0.0	3.3	33.4	48.5	41.9	25.1	10.4
NJ	21.2	0.1	4.2	24.4	31.6	28.7	21.5	12.4
PA	22.6	0.0	2.6	25.0	34.3	30.8	23.8	13.1
Study States Combined	23.7	0.0	3.2	27.4	37.5	33.0	23.5	12.4
Other Reporting States	28.1	0.4	9.8	34.2	41.8	37.3	26.9	13.7
Total Reporting States	27.7	0.4	9.3	33.7	41.5	37.0	26.7	13.6

Source: FY2006 CMS-416 reports, provided to CRS as of August, 28, 2008. Data for Kentucky, Maine and Vermont were not available, and thus, these states are excluded from these analyses.

Receipt of Dental Treatment Services. The data patterns for receipt of dental treatment services (see **Table 5**) are similar to those described above for receipt of any and preventive dental services among children under 21. These data do not account for the need for dental treatment, only whether or not such treatment was provided. In general, fewer children receive dental treatment services than receive preventive dental care.

Table 5. Percentage of EPSDT Eligibles Receiving Dental Treatment Services by Age Group, FY2006

States	Total	Under 1	1 to 2	3 to 5	6 to 9	10 to 14	15 to 18	19 to 20
AZ	18.2	0.1	2.3	21.0	31.4	25.2	18.7	10.7
NJ	15.3	0.1	1.9	13.5	21.3	21.4	20.6	14.6
PA	13.1	0.0	1.3	10.9	18.8	17.4	17.0	12.5

Study States Combined	15.0	0.1	1.7	14.6	23.0	20.3	18.2	12.5
Other Reporting States	17.6	0.1	2.6	17.3	26.3	23.9	21.7	13.3
Total Reporting States	17.4	0.1	2.5	17.3	26.1	23.7	21.5	13.2

Source: FY2006 CMS-416 reports, provided to CRS as of August, 28, 2008. Data for Kentucky, Maine and Vermont were not available, and thus, these states are excluded from these analyses.

Conclusions

While progress has been made by states to provide dental services to Medicaid children, recent statistics indicate that more work needs to be done in this area. States with higher levels of dental care among Medicaid children may be able to provide guidance on their successes and failures to other states with lower levels of dental care. A parallel effort across Medicaid managed care plans may also be fruitful. Such efforts could be organized and facilitated by various federal agencies, including, for example, CMS, Centers for Disease Control and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ), and the National Institute of Dental and Craniofacial Research.